



# Medicaid Questions on the CMS EHR Incentive Program Final Rule

August 5, 2010

1. **If an eligible professional (EP) adopts, implements or upgrades to certified EHR technology (AIU) in Jan 2012 and gets the AIU payment in 2012, can the EP use a 90-day period in 2012 to report on EHR meaningful use (MU) for a 2013 Year 1 MU payment? Or, does the 90-day period have to be in the next calendar year 2013? Then they would have to show Year 2 MU in calendar year 2014 and not get their next incentive payment until sometime in 2015.**

First, it is important to note that when discussing 2013, CMS stated that it expects to engage in another cycle of rulemaking for that year. Under our current rules, the 90-day period has to be in the next calendar year 2013. Payment year is defined in 42 CFR 495.4 as a calendar year beginning with CY 2011, and for Medicaid, the first payment year is the first calendar year for which the EP receives an incentive payment. The second payment year is then the second calendar year for which the EP receives the incentive payment. Because each payment year is tied to a separate calendar year, and because for Medicaid, for the first year of demonstrating MU the EHR reporting period must be a continuous 90-day within the calendar year (with all subsequent years having an EHR reporting period equal to the full CY), the EHR reporting period must occur within the year of payment. Thus, the EHR reporting period is any 90-day period within CY 2013 in the example provided above. As for what stage of meaningful use the EP must show in CY 2014, CMS stated that it expects to engage in future rulemaking to address this issue.

2. **The billing provider on a claim is an EP but the performing provider type is not an EP. If we use claims to validate patient volume or meaningful use, should we count performing providers (person rendering the service) or the billing provider?**

In establishing an encounter for purposes of patient volume, please see the regulations at 495.306(e)(2)(i)-(ii) at 75 FR 44579 . Furthermore, in estimating patient volume for any EP or hospital, we do not specify any requirements around billing, but rather we discuss patients. E.g., if a Physician's Assistant (PA) provides services, but they are billed through the supervising physician, it seems reasonable that a State has the discretion to consider the patient as part of the patient volume for both professionals. However, this policy would need to be applied consistently. In this scenario, using services provided by the PA but billed under the physician in the physician's numerator (e.g., Medicaid encounters) also would increase the physician's denominator (all encounters), because the State would need to adequately reflect the total universe of patients (both Medicaid and non-Medicaid) who the PA saw, but for whom the physician billed.

In terms of meaningful use, because each eligible professional must demonstrate meaningful use him/herself, if the State could not distinguish between the physician's claims and the PA's individual claims, then this would not be an adequate audit methodology.

3. **I am interested in finding out how we should determine the cost of an EHR system to a provider in order for them to demonstrate their 15% of the net average allowable costs for an EHR in the following scenarios:**
- a. **It is a group practice, owned by the clinicians. The cost of purchasing and implementing an EHR system was \$300,000 and there are 30 clinicians.**
    - i. Each eligible clinician reports \$300,000; or
    - ii. Each eligible clinician reports \$10,000 ( $\$300,000/30 \text{ clinicians} = \$10,000$ ) as their contribution. This is the correct approach.
  - b. **It is a group practice, privately owned. The cost of purchasing and implementing an EHR system was \$300,000 and there are 30 employee clinicians.**
    - i. Each eligible clinician reports \$300,000; or
    - ii. Each eligible clinician reports \$10,000 ( $\$300,000/30 \text{ clinicians} = \$10,000$ ) as their contribution. This is the correct approach.
  - c. **The cost of purchasing and implementing an EHR system was \$300,000 and there are 30 employee clinicians at an FQHC/RHC. These costs were paid for through a Federal grant.**
    - i. Each eligible clinician reports that the system cost \$300,000; or
    - ii. Each eligible clinician reports the sum of the costs that s/he personally incurred to connect to the system, internet access, or any hardware, or software, or training expenses; or
    - iii. If all of the EHR software, licensing, training, hardware, internet and related software costs were paid by the FQHC with Federal funds, the eligible clinicians would report \$0 as their contribution; or
    - iv. Each eligible clinician reports \$10,000 ( $\$300,000/30 \text{ eligible clinicians} = \$10,000$ ) as their contribution. This is the correct approach.

**4. Is it acceptable to borrow material from the slide deck that was used during the 7-19 CMS HITECH call?**

They may be reused, but some of the slides had minor modifications needed. CMS will post a corrected, 508-compliant version on our website as soon as possible. It is not permissible to reproduce the CMS logo or the CMS EHR Incentive Program logo.

**5. Do States need to verify the "installation" or "a signed contract" for AIU?**

States should make clear to providers when they attest for AIU what documentation they must maintain, and for how long, in case of audit. If States determine that certain provider types are a high risk for potential fraud/abuse for AIU, then they can ask for some verification of adopting, implementation or upgrading but CMS encourages that this be done in a targeted manner, with the most electronic and simple means possible and not in such a way that would be burdensome to providers. For AIU, a provider does not have to have installed certified EHR technology. The definition of AIU in 42 CFR 495.302 allows the provider to demonstrate AIU through any of the following: (a) acquiring, purchasing or securing access to certified EHR technology; (b) installing or commencing utilization of certified EHR technology capable of meeting meaningful use requirements; or (c) expanding the available functionality of certified EHR technology capable of meeting meaningful use requirements at the practice site, including staffing, maintenance, and training, or upgrade from existing EHR technology to certified EHR technology per the ONC EHR certification criteria. Thus, a signed contract indicating that the provider has adopted or upgraded would be sufficient.

**6. When we count encounters in a clinic or medical group (or medical home model) are we able to include the encounters of ancillary providers such as pharmacists, educators, etc. when determining if the EPs are eligible, per patient volume requirements?**

Our regulations did not address whether these non-EP encounters could be considered in the estimate of patient volume for the clinic. However, we believe a State would have the discretion to include such non-EP encounters in its estimates. Again, if these non-EP encounters are included in the numerator, they must be included in the denominator as well. States also must ensure that their methodology adheres to the conditions in 42 CFR 495.306(h), and specifically to 495.306(h)(4), which says: "(4) The clinic or group practice uses the entire practice or clinic's patient volume and does not limit patient volume in any way."

**7. If the EHR Reporting Period is CY 2013, then the Payment Year also refers to 2013 even though an EP may receive the actual incentive payment in early 2014, correct? If this is the case, does "preceding year" mean that the number of patient encounters in any 90 day period in CY 2012 will be used? If so, why not use the number of patient encounters during CY 2013?**

The payment year is the year for which the payment is made (see 42 CFR 495.4 and the definition of "First, second, third, fourth, fifth, or sixth payment years."). So, the questioner is correct that if the EHR reporting period is in CY 2013, the payment year also refers to 2013. Using the patient encounters from the year preceding the payment year, when the EP is AIU, or in the first year of MU, when the EHR reporting period is 90 days, allows the EP to receive an

incentive early in the payment year, such as when their EHR reporting period occurs during the first 90 days of CY 2012).

- 8. Can EPs count their costs towards the initial purchase of the EHR, not just what they will spend to upgrade it to the newly certified version, for purposes of 15% of the net average allowable cost? How far back in time can an EP count his/her contribution towards EHR technology for the purposes of demonstrating 15% of the net average allowable cost (NAAC) (\$3750 in year 1; \$1500 in years 2-6)? Can they “carry-over” those expenses for the subsequent years?**

Yes, a State may, in its SMHP, use a methodology that allows the EP to count their initial costs, as one cannot upgrade that which one does not have (i.e. you have to have "version 1.0" in order to upgrade to "version 2.0") There is no prescribed timeframe. For example, if an EP expended \$5000 in 2007 on an EHR and spends \$2000 in 2010 for the newly certified version, his/her total costs would be \$7,000. As the rule indicates that an EP must demonstrate 15% of the NAAC, which for the first participation year is \$3,750, that EP would have clearly met that requirement. However, the EP cannot “carry-over” from year to year, and must demonstrate that s/he has met the 15% of the NAAC for each year. So, for participation years 2-6, the EP would need to attest to the State that they have expended at least \$1500 towards their meaningful use of certified EHR technology. We provide examples in the preamble of the final rule (75 FR 44492-4), such as health information exchange transaction fees/monthly dues; costs associated with internet access; computer hardware; additional software upgrades; training/technical assistance fees, etc.

- 9. When should we expect to receive the hospital interface attestation info.....same day, next day, weekly etc.?**

Almost all file transfers are daily. However, at first, States will just receive confirmation that the dually-eligible hospital attested, not the underlying info. Once we have a user interface for States, you will be able to look at the attestation module.

- 10. Can NLR information be updated by the provider at the NLR level (i.e. an address was transposed)? If so, will the States receive an update or full refresh of this information?**

Yes, if there are errors like that, a provider will need to correct at the registration module in the NLR. An updated file will be sent to the State.

- 11. How can the state determine what, if any, other funds a provider may have received for adopting EHR technology?**

**a. What data sources can we utilize to determine that information?**

One option is that States can employ an attestation model. We believe this might be similar to individuals reporting deductions on income taxes, for example. Providers could use worksheets to make a qualification determination, but are still subject to an audit by the State. CMS plans to develop templates for these worksheets to share with States.

**12. What's been CMS's general turnaround time for feedback on informal SMHP drafts?**

ASAP, but no guaranteed timeframe.

**13. It seems that each State has the latitude to define the 12-month period from which to derive the Medicaid share data. Neither the preamble nor the regulatory text explicitly stipulate that the 12-month period selected by the state for the Medicaid share data needs to be in the federal FY before the hospital's FY that serves as the first payment year. Am I correct in this interpretation? In other words, a state could use two different 12-month periods to calculate the discharge-related amount and the Medicaid share?**

No, this is not correct. The regulation is clear that the discharge-related amount must be calculated using a 12-month period that ends in the Federal fiscal year before the hospital's fiscal year that serves as the first payment year. 42 CFR 495.310(g)(1)((i)(B). This statement also was made in the preamble, where we stated: "For purposes of administrative simplicity and timeliness, we require that States use data on the hospital discharges from the hospital fiscal year that ends during the Federal fiscal year prior to the fiscal year that serves as the first payment year" 75 FR 44498. In addition, the regulation indicates that the period that is used for the Medicaid share is the same period as that used for the discharge-related amount. See 42 CFR 495.310(g)(2)(i) referring to "the 12-month period selected by the State." Use of "the" in 495.310(g)(2) indicates that this is the same 12-month period that is used under 495.310(g)(1). In addition, we believe that using different periods for the Medicaid share versus the discharge-related amount would lead to inaccurate estimates, as data would be drawn from inconsistent periods.

**14. On Table 19 (75 FR 44499) - It seems that the table should say FY rather than CY; which is correct?**

Yes, it should say FY, which is what is used throughout the preamble and regulation.

**15. Are EPs who practice in State Mental Health and Long Term Care Facilities eligible for Medicaid incentive payments if they meet the eligibility criteria (e.g., patient volume, non-hospital based, certified EHR)?**

The setting in which a physician, nurse practitioner, certified nurse midwife, or dentist provides care is generally irrelevant to determining eligibility for the incentive program (except for purposes of determining whether an EP can qualify through "needy individual" patient volume). Setting is relevant for physician assistants, as they are eligible only when they are practicing at a Federally Qualified Health Center (FQHC) that is led by a PA or a Rural Health Center (RHC) that is so led. All providers must meet all program requirements prior to receiving an incentive payment (e.g. adopt, implement or meaningfully use certified EHR technology, patient volume, etc.).

- 16. If a State had their incentive payment program approved and ready to go by 1/1/2011, could a provider use for their 90-day patient volume period 10/1-12/31/2010 to qualify for a payment as of 1/1/2011?**

Yes. We specify that the volume period needs to be any 90-day period in the preceding calendar year. The provider would also need to demonstrate A/I/U in order to qualify for an incentive payment.

- 17. If a provider AIU in their first year, the provider will not have to demonstrate meaningful use in order to receive payment; in the second year they will have to demonstrate MU for a 90 day period only. Whereas a provider that is already a meaningful user would have to demonstrate for a 90 day period the first year and subsequent years they would have to demonstrate it for the full year. Is this correct?**

This is correct.

- 18. If patients are dually eligible, Medicare and Medicaid, can they be counted twice by hospitals in their calculations for incentive payment if they are applying for both Medicare and Medicaid?**

For purposes of calculating the Medicaid share, a patient cannot be counted in the numerator if they would count for purposes of calculating the Medicare share. Thus, in this respect the inpatient bed day of a dually eligible patient could not be counted in the Medicaid share numerator. (See 1903(t)(5)(C), stating that the numerator of the Medicaid share does not include individuals “described in section 1886(n)(2)(D)(i).”) In other respects; however, the patient would count twice. For example, in both cases, the individual would count in the total discharges of the hospital.

- 19. Can organizations register for the Medicaid EHR Incentive Program on behalf of their eligible professionals?**

There is nothing preventing this. Anyone doing this on behalf of providers would need to have an Identity & Account (I&A) Management user ID/pw for NPPES.

- 20. Can organizations request payments for the Medicaid EHR Incentive Program on behalf of their eligible professionals including attesting to required information?**

The EPs are legally attesting that they meet the requirements in order to receive payments. States could consider a model similar to that used for tax preparation, where a preparer (accountant) completes the information, but the individual still signs the forms. We recommend consulting with your legal department about your current rules for claims submissions, and ensuring that the EPs remain liable under the False Claims Act and other fraud, waste and abuse provisions. Furthermore, we want to ensure providers know that an attestation is being submitted on their behalf—as there may be EPs in multiple practices that want to direct the incentive to one particular practice.



**21. In the event EPs have more than allowable cost in a given year, can they carry-over excess costs to future years?**

We did not set up parameters for this in the final rule. Only if there was an on-going aspect to that cost, not a one-time expenditure. States will have to define this clearly for their programs.

**22. For calculation of the hospital incentive, is the estimated growth rate for hospitals most recent three years based on growth in total days or growth in discharges? (The data sources for these are different.)**

The average annual growth rate should be for discharges (see 1903(t)(5)(B), referring to the annual rate of growth of the most recent 3 years for “discharge data.”) We agree that the sources are different. Hospitals would probably have to use MMIS or auditable hospital records to get accurate discharge data rate of growth.

**23. Is data sharing with neighboring States permitted regarding total Medicaid days for purposes of paying full incentives to hospitals or EPs with utilization in multiple states?**

Yes. The CMS final rule clarifies the policy about calculating patient volume for Medicaid providers with clinical practices in more than one State, both in terms of what is “Medicaid patient volume” and about the cross-border issue. See 75 FR 44503, stating: “[W]e recommend that States consider the circumstances of border State providers when developing their policies and attestation methodologies. To afford States maximum flexibility to develop such policies, we will not be prescriptive about whether a State may allow a Medicaid EP to aggregate his/her patients across practice sites, if the State has a way to verify the patient volume attestation when necessary. States will propose their policies and attestation methodologies to CMS for approval in their State Medicaid HIT plans.” However, as stated in the final rule, EPs and hospitals are permitted to receive payment from only one State in a payment year (495.310(e)).

**24. Does a State have the option of solely using a state-submitted alternative methodology (pending CMS approval) for determining patient volume, or is the State additionally required to use one of the CMS specified methodologies (patient encounter or patient volume)?**

Yes, the State can submit to us for approval only the alternative methodology that meets the requirements of 495.306(g). As we stated in the preamble to the final rule, we believe most States will not submit alternative methodologies until after the first year of the program, allowing for alternatives to recognize evolving State and provider experience with patient volume estimate methodologies. We recommend that States consider the methodologies that were put forward in the final rule, prior to proposing only an alternative in their SMHPs. If a State alternative methodology is approved by us, we will post this methodology on our website, so that other States may adopt the methodology as well.

**25. We are trying to determine if the physicians who work in a tribally operated facility (called 638) who meet the Medicaid volume requirements and are hired directly by the facility would be eligible for Medicaid incentive payments?**

Physicians are one of the categories of eligible professionals. If they meet the other Medicaid eligibility requirements, such as patient volume, AIU or MU of certified EHR technology, non-hospital based, etc, then the fact that they work at a tribally-operated facility and are direct hires or not is not relevant. We believe the questioner may be concerned about calculating net average allowable costs and/or ensuring that the EPs working in the facility are determined to have met their 15% responsibility. However, without more information on these aspects of the question, we cannot provide a response.

**26. Are pediatric subspecialists considered pediatricians for purposes of qualifying under Medicaid meaningful use? In other words, if I am an otolaryngologist who only sees children, can I qualify under Medicaid if I only have 20% of patient volume as Medicaid?**

For the Medicaid EHR Incentive Program, States will define “pediatrician” in a manner consistent with how they define the term for other purposes of their Medicaid programs.

**For more information, go to:**  
[www.cms.gov/EHRIncentivePrograms](http://www.cms.gov/EHRIncentivePrograms)

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